IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7007 0710 0002 7979 0871

November 4, 2010

RECEIVED
DEC 0 3 2010
FACILITY STANDARDS

Tom Moss, Acting Administrator
Preferred Community Homes - Courtyard
7091 W Emerald
Boise, ID 83704

RE: Preferred Community Homes - Courtyard, Provider #13G057

Dear Mr. Moss:

Based on the follow-up survey completed at Preferred Community Homes - Courtyard on October 27, 2010, by our staff, we have determined that Preferred Community Homes - Courtyard is out of compliance with the Medicaid Intermediate Care Facility for Persons with Mental Retardation (ICF/MR) Conditions of Participation on **Active Treatment Services (42 CFR 483.440); Client Behavior & Facility Practices (42 CFR 483.450).** To participate as a provider of services in the Medicaid program, an ICF/MR must meet all of the Conditions of Participation established by the Secretary of Health and Human Services.

The deficiencies which caused these Conditions to be unmet, substantially limit the capacity of Preferred Community Homes - Courtyard to furnish services of an adequate level or quality. The deficiencies are described on the enclosed Statement of Deficiencies/Plan of Correction (CMS-2567). A similar form indicates State Licensure deficiencies.

You have an opportunity to make corrections of those deficiencies, which led to the finding of non-compliance with the Conditions of Participation referenced above by submitting a written Credible Allegation of Compliance. Such corrections must be achieved and compliance verified, by this office, before **December 11, 2010**. **To allow time for a revisit to verify corrections prior to that date, your Credible Allegation must be received in this office no later than November 30, 2010**.

The following is an explanation of a credible allegation:

Credible allegation of compliance. A credible allegation is a statement or documentation:

- Made by a provider/supplier with a history of having maintained a commitment to compliance and taking corrective actions if required.
- That is realistic in terms of the possibility of the corrective actions being accomplished between the exit conference and the date of the allegation, and
- That indicates resolution of the problems.

In order to resolve the deficiencies the facility must submit a letter of credible allegation to the Department, which contains a sufficient amount of information to indicate that a revisit to the facility will find the problem corrected.

As mentioned above, the letter of credible allegation must indicate that the problems have been corrected as of the date the letter is signed. Hence, a plan of correction indicating that the correction(s) will be made in the future would not be acceptable. Please keep in mind that once the Department receives the letter of credible allegation, an unannounced visit could be made at the facility at any time.

Failure to correct the deficiencies and achieve compliance will result in our recommending that the Medicaid Agency terminate your approval to participate in the Medicaid Program. If you fail to notify us, we will assume you have not corrected.

Be advised, that, consistent with IDAPA 16.05.03.300, you are entitled to request an administrative review regarding the issuance of the provisional license. To be entitled to an administrative review, you must submit a written request by **December 2, 2010**. The request must state the grounds for the facility's contention of the issuance of the provisional license. You should include any documentation or additional evidence you wish to have reviewed as part of the administrative review.

Your written request for administrative review should be addressed to:

Randy May, Deputy Administrator
Division of Medicaid -- DHW
PO Box 83720
Boise, ID 83720-0036
Phone: (208)364-1804
Fax: (208)364-1811

If you fail to submit a timely request for administrative review, the Department of Health and Welfare's decision to issue the provisional license becomes final. Please note that issues, which are not raised at an administrative review, may not be later raised at higher level hearings (IDAPA 16.05.03.301).

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informal Dispute Resolution (IDR) Process which can be found on the Internet at:

www.icfmr.dhw.idaho.gov

Scroll down until the Program Information heading on the right side is visible and there are three IDR selections to choose from.

This request must be received by November 17, 2010. If a request for informal dispute resolution is received after November 17, 2010 the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

We urge you to begin correction immediately. If you have any questions regarding this letter or the enclosed reports, please contact me at (208)334-6626.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm
Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	13G057	A. BUILDING _____ B. WING _____	R-C 10/27/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

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(W 000)	INITIAL COMMENTS The following deficiencies were cited during the follow up survey. The survey was conducted by: Michael Case, LSW, QMRP, Team Leader Monica Nielsen, QMRP Common abbreviations/symbols used in this report are: ADHD - Attention Deficit Hyperactivity Disorder AQMRP - Assistant Qualified Mental Retardation Professional BIP - Behavior Intervention Program HRC - Human Rights Committee Mandt - A physical restraint system OCD - Obsessive Compulsive Disorder PCLP - Person Centered Life Plan RN - Registered Nurse RSC - Residential Service Coordinator QMRP - Qualified Mental Retardation Professional	(W 000)	**W 000 INITIAL COMMENTS** "Preparation and implementation of this plan of correction does not constitute admission or agreement by Courtyard with the facts, findings or other statements as alleged by the state agency dated October 27, 2010. Submission of this plan of correction is required by law and does not evidence the truth of any or some of the findings as stated by the survey agency. Courtyard – Preferred Community Homes, specifically reserves the right to move to strike or exclude this document as evidence in any civil, criminal or administrative action."	
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility's governing body failed to take actions that identified and resolved systematic problems for the individuals residing at the facility. This failure directly impacted 3 of 3 individuals reviewed (Individuals #1 - #3), and had the potential to negatively impact 6 of 6 individuals (Individuals #1 - #6) residing at the facility. This failure resulted in a lack of accurate	W 104	**W 104 483.410(a)(1) GOVERNING BODY** Please refer to the responses given for W124, W137, W159, W214, W227, W237, W239, W249, W278 and W313. To correct the deficiencies the Westcare Regional Representative and the Assistant to the Regional have stepped in as the QIDP's for all of the individuals at the Courtyard home to assist with all functions of the QIDP. They have physically been in Wendell assisting with the revisions throughout the process. They have been assisting with staff training to assure that all staff	

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FACILITY STANDARDS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Tom Wells | Assistant to the Regional | 12/1/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 104	Continued From page 1 and comprehensive assessments, appropriate objectives, development and implementation of training programs, and appropriate monitoring of active treatment and behavioral services. The findings include: 1. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring sufficient information was provided to parents/guardians on which to base consent decisions. The facility was previously cited at W124 during a complaint survey dated 9/16/10. 2. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring individuals had access to their personal possessions. The facility was previously cited at W137 during a complaint survey dated 9/16/10. 3. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to the failure to ensure individuals' services were sufficiently coordinated and monitored by the QMRP. The facility was previously cited at W159 during a complaint survey dated 9/16/10. 4. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring behavioral assessments were accurate and included comprehensive information. The facility was previously cited at W214 during a complaint survey dated 9/16/10. 5. The governing body failed to provide sufficient operating direction over the facility to ensure	W 104	are being and will continually be trained on all programs, as they are implemented. On the floor training has occurred and will continue to occur until we believe staff has adequate training to implement the active treatment program as written. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent.	

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W 104	Continued From page 2 correction of past deficiencies related to ensuring individuals' PCLPs included objectives to meet their needs. The facility was previously cited at W227 during a complaint survey dated 9/16/10. 6. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring the collection of data was accurate and allowed the team to make informed decisions on the effectiveness of program strategies. The facility was previously cited at W237 during a complaint survey dated 9/16/10. 7. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring appropriate replacement behaviors were identified and incorporated into the behavior intervention programs. The facility was previously cited at W239 during a complaint survey dated 9/16/10. 8. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring individuals received training and services consistent with their PCLPs. The facility was previously cited at W249 during a complaint survey dated 9/16/10. 9. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior. The facility was previously cited at W278 during a complaint	W 104	Person Responsible: Westcare Regional Representative Completion Date: 1/1/11	

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W 104	Continued From page 3 survey dated 9/16/10. 10. The governing body failed to provide sufficient operating direction over the facility to ensure correction of past deficiencies related to ensuring behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs. The facility was previously cited at W313 during a complaint survey dated 9/16/10. These systematic failures resulted in the facility's inability to provide individuals with appropriate programs necessary to meet their developmental and behavioral needs.	W 104	**W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS** The written informed consents for individual #3 have been revised to include sufficient information and reviewed with his guardian. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including the written informed consents. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent.	
{W 124}	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure sufficient information was provided to parents/guardians on which to base consent decisions for 1 of 3 individuals (Individual #3) whose written informed consents were reviewed. This resulted in a lack of information being provided to an individual's guardian regarding restrictive interventions. The findings include: 1. Individual #3's 9/28/10 PCLP stated he was a	{W 124}		

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{W 124}	Continued From page 4 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. a. Individual #3's Physician's Order, dated 8/10, documented he received Risperidone (an antipsychotic drug) 3 mg each evening. Individual #3's Written Informed Consent for Risperidone, dated 8/24/10, stated the drug "should further increase [Individual #3's] ability to follow instructions and increase his time on task." Individual #3's Medication Reduction Plan, dated 10/20/10, stated the drug was for aggression, defined as hitting, slapping, and attempts to hit or slap. Individual #3's Written Informed Consent did not clearly define the intended outcome of the drug. Without clear information about the intended outcome of the drug, it would not be possible for Individual #3's guardian to make an informed decision regarding its use. During an interview on 10/27/10 from 8:33 - 11:15 a.m., the AQMRP stated Individual #3's consent for Risperidone had not been revised to include accurate information regarding the use of the drug. The facility failed to ensure Individual #3's Written Informed Consent for Risperidone contained sufficient information for his guardian to make informed treatment decisions. b. Individual #3's record contained a Resident Medication Change Form, dated 9/20/10, which stated Clonidine (an antihypertensive drug) was to be started at 0.1 mg ½ tablet twice a day for 1	{W 124}	Person Responsible: Westcare Regional Representative Completion Date: 1/1/11	

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{W 124}	Continued From page 5 week, then increased to 1 tablet twice a day. The form documented telephone consent had been received from the guardian on 9/24/10 and from the HRC on 9/27/10. However, the document did not contain information related to the drugs intended use or potential risks. Individual #3's record contained a second Resident Medication Change Form, dated 10/15/10, which stated Clonidine was to be increased to 0.1 mg three times daily. The form documented telephone consent had been received from the guardian on 10/18/10 and from the HRC on 10/19/10. However, the document did not contain information related to the drugs intended use or potential risks. During an interview on 10/27/10 from 8:33 - 11:15 a.m., the AQMRP stated she had not yet completed the written informed consent. When asked what information had been presented to the guardian on which to make decisions regarding the drug, the AQMRP stated she had gone over drug side effect information she pulled from the internet with the guardian. When asked about the drugs intended use, the AQMRP stated she had not reviewed that information with the guardian. The facility failed to ensure sufficient information was provided to Individual #3's guardian with which to make informed decisions regarding the addition of Clonidine to his drug regimen. Repeat Deficiency.	{W 124}	**W 137 483.420(a)(12) PROTECTION OF CLIENTS RIGHTS** All of the grooming kits have been unlocked and each individual has access to their grooming kit. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including protecting their rights. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent.	
{W 137}	483.420(a)(12) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients.	{W 137}		

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{W 137}	Continued From page 6 Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure individuals had access to their personal possessions for 6 of 6 individuals (Individuals #1- #6) residing in the facility. This resulted in individuals not being able to freely access their grooming kits. The findings include: 1. An observation was conducted on 10/25/10 from 7:00 - 8:15 a.m. During that time staff were noted to take individuals into the laundry room to obtain their grooming kits from a locked cabinet. The cabinet was observed to contain grooming kits for all six individuals residing in the facility. Individuals' grooming kits were noted to include their tooth brushes, tooth paste, combs, hair brushes, deodorant, and other personal grooming items. During an interview on 10/27/10 from 8:33 - 11:15 a.m., the Acting QMRP stated the facility had misunderstood what toxic chemicals were and thought grooming supplies were required to be stored under locked conditions. The facility failed to ensure individuals had access to their grooming kits. Repeat Deficiency.	{W 137}	Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	
{W 159}	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be	{W 159}	**W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL** The floor books in the home have been revised to include the current PCLP information and training plans. The progress notes for each individual have also been revised and are currently up to date so that progress and regression can be monitored.	

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{W 159}	Continued From page 7 integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure the QMRP provided sufficient monitoring and coordination which directly impacted 3 of 3 individuals (Individuals #1 - #3) reviewed, and had the potential to impact 6 of 6 individuals (Individuals #1 - #6) residing in the facility. That failure resulted in individuals not receiving the necessary assessments, training, and monitoring required to meet their behavioral needs. The findings include: 1. On 10/26/10 at 1:00 p.m., Individuals #1 - #3's program books used by staff (floor books), were reviewed and compared to Individuals #1 - #3's program charts located in the facility's office. The floor books did not contain their current PCLP (all dated 9/28/10) and related training plans. Additionally, each floor book contained their BIP, Behavior Slips, and training plans related to their previous PCLP. Further, Individual #1 and Individual #2's floor books each contained a list of fine motor activities, a list of gross motor activities, and a list of recreation and leisure activities. It was noted the lists were identical. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., current PCLPs had not been put in the floor books yet, related training plans had not been developed for Individuals #1 and #2, and training	{W 159}	In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including monitoring the floor books and making program revisions. An QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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{W 159}	Continued From page 8 plans were developed but were not implemented for Individual #3. The Acting QMRP stated they had been focused on revising and training staff on individuals' BIPs. When asked about the lists of activities noted above, the AQMRP, who was present during the interview, stated the lists were general and were not individualized based on the individuals' needs. When asked, the RSC, who was also present during the interview, stated she was not sure whether materials related to the listed activities were available for staff and individuals. The facility failed to ensure Individuals #1 - #3's floor books contained current PCLPs and related training programs, and that the lists of activities were individualized and associated materials were available for staff and individuals. 2. When asked for progress and regression program notes for Individuals #1 - #3, the AQMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., notes had not been completed for any individuals since 6/10. The facility failed to ensure program notes were completed in a timely fashion in order to assess Individuals #1 - #3's progress and regression. 3. Refer to W124 as it relates to the facility's failure to ensure the QMRP ensured an individual's written informed consents for restrictive interventions contained sufficient information. 4. Refer to W137 as it relates to the facility's failure to ensure the QMRP ensured individuals' had access to their personal possessions.	{W 159}	~~Please refer to W124 as it relates to~~ written informed consents. Please refer to W137 as it relates to personal possessions. Please refer to W186 as it relates to facility staffing. Please refer to W214 as it relates to behavioral assessments. Please refer to W218 as it relates to sensorimotor assessments. Please refer to W227 as it relates to the development of objectives. Please refer to W237 as it relates to data collection. Please refer to W239 as it relates to the development of replacement behaviors. Please refer to W241 as it relates to the location of the PCLP. Please refer to W242 as it relates to communication. Please refer to W248 as it relates to assuring that PCLP's were available for staff. Please refer to W249 as it relates to development and implementation of the training plans. Please refer to W278 as it relates to less restrictive interventions. Please refer to W313 as it relates to ensuring behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the risk of the drugs. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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{W 159}	Continued From page 9 5. Refer to W186 as it relates to the facility's failure to ensure the QMRP ensured sufficient numbers of direct care staff were available to meet individuals' needs. 6. Refer to W214 as it relates to the facility's failure to ensure the QMRP ensured behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 7. Refer to W218 as it relates to the facility's failure to ensure the QMRP ensured sensorimotor assessments were updated and accurately identified an individual's sensory needs. 8. Refer to W227 as it relates to the facility's failure to ensure the QMRP ensured objectives were developed to address individuals' needs. 9. Refer to W237 as it relates to the facility's failure to ensure the QMRP ensured data collection was sufficient to determine the efficacy of individuals' behavior intervention strategies. 10. Refer to W239 as it relates to the facility's failure to ensure the QMRP ensured the replacement plans for individuals' maladaptive behavior were developed to meet their behavioral needs. 11. Refer to W241 as it relates to the facility's failure to ensure the QMRP ensured individuals' PCLPs identified the location where program strategy information could be found. 12. Refer to W242 as it relates to the facility's failure to ensure the QMRP ensured individuals received training related to their communication	{W 159}		

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{W 159}	Continued From page 10 needs. 13. Refer to W248 as it relates to the facility's failure to ensure the QMRP ensured individuals' PCLPs were available to direct care staff. 14. Refer to W249 as it relates to the facility's failure to ensure the QMRP ensured individuals' training plans were developed and implemented. 15. Refer to W278 as it relates to the facility's failure to ensure the QMRP ensured less restrictive interventions were systematically tried and proven to be ineffective prior to implementing restrictive interventions. 16. Refer to W313 as it relates to the facility's failure to ensure the QMRP ensured behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the associated risks of the drugs. Repeat Deficiency.	{W 159}		
W 186	483.430(d)(1-2) DIRECT CARE STAFF The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. Direct care staff are defined as the present on-duty staff calculated over all shifts in a 24-hour period for each defined residential living unit. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to provide sufficient direct care staff to manage and supervise an individual in accordance with his	W 186	**W 186 483.430(d)(1-2) DIRECT CARE STAFF** Individual #3 is currently assigned a one to one staff as part of his program plan. Currently there are 5 staff assigned to the AM and PM shifts at the home. Preferred Community Homes has scheduled quarterly core team meetings. At the meetings the team will discuss the needs of each individual so that the team can assure that all needs are met including the staffing needs of each individual. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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W 186	Continued From page 11 PCLP for 1 of 5 individuals (Individual #3) whose PCLPs were reviewed. This resulted in another individual's treatment being continuously disrupted and had the potential to impede staffs' ability to consistently meet other individuals' identified needs. The findings include: 1. The facility housed six individuals diagnosed with moderate to profound mental retardation, whose ages ranged from 12 to 21 years old. During the entrance conference on 10/25/10 at 12:35 p.m., the Acting QMRP stated the facility utilized 4 staff on both the a.m. and p.m. shifts. The Acting QMRP stated Individual #1 and Individual #5 required one-to-one staffing due to their behavior needs. The Acting QMRP stated during the entrance conference that Individual #2 and Individual #6 were grouped and had one staff working with them, and Individual #3 and Individual #4 were grouped and had one staff working with them. Individuals #1 - #6's records were reviewed and showed their needs, as follows: a. Individual #1's PCLP, dated 9/28/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. He communicated by using 1 - 4 word utterances and gestures. His PCLP stated he required full physical assistance to complete all areas of housekeeping, meal planning and preparation, and traffic safety and survival skills. He required light physical prompts to button his pants, and	W 186		

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W 186	Continued From page 12 verbal prompts to wipe after voiding, complete shower/bath tasks, wash his face, brush his teeth, complete shaving and nail care tasks, to change bed linens and make his bed, to use a knife, to scoop food from a jar with a utensil, open a carton of liquid, and mix ingredients with a spoon, to wipe up his own spills, and to complete money management and shopping tasks. Individual #1's BIP, dated 10/20/10, stated he engaged in physical aggression (defined as hitting, biting, pinching, scratching, kicking, shoving, and head butting), self abuse (defined as biting self, hitting self, and head banging), and elopement (defined as leaving the facility without staff). His BIP stated he required one to one staff within arms length during waking hours due to his "severe self injurious behavior." b. Individual #2's PCLP, dated 9/28/10, documented a 17 year old male diagnosed with profound mental retardation, autism, and seizure disorder. He communicated by facial expressions, body positioning, and maladaptive behaviors. Additionally, "He initiates and requests by reaching toward people or objects and protests by pushing the item away or moving away himself." His PCLP documented he required full physical assistance to complete most areas of toileting, all showering/bathing, hand washing, face washing, tooth brushing, grooming, hair care, dressing, bed making, housekeeping, eating and dining, cooking and food preparation, travel, and money management. He required verbal prompts to slow down when eating, walk from room to room,	W 186		

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W 186	Continued From page 13 to undress, sit, void and flush the toilet, and turn on water. His BIP, dated 10/13/10, stated he engaged in physical aggression towards others (defined as hitting, pinching, scratching, slapping, and pulling hair), self abuse (defined as hitting self, biting self, and banging his head), uncooperative behavior (defined as refusals and leaving a designated area unassisted), pica (defined as eating non-food items), rumination (defined as bringing ingested food back up in his mouth), and food stealing. c. Individual #3's PCLP, dated 9/28/10, documented a 12 year old male diagnosed with profound mental retardation, ADHD, and autism. He communicated by gesture and touch. His PCLP stated he "requires assistance in most of the areas of self help" and he "is so busy running in different directions it is hard for the staff to get him to focus." His PCLP documented he required full physical assistance to complete most areas of showering/bathing, dress and undress, complete most housework tasks, all areas of cooking and food preparation, travel, and money management. He required light to full physical assistance to complete hand washing, face washing, tooth brushing, grooming, make his bed, and care for his clothing. He required verbal prompts to complete all areas of toileting, turn off water, slow down when eating, chew appropriately, place the correct amount of food on his plate, use correct utensils, and fill a cup at the sink with the correct amount of fluid, and full physical assistance for all other eating and dining	W 186		

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W 186	Continued From page 14 tasks. He required staff to complete his hair care and tooth flossing. Individual #3's BIP, dated 10/13/10, documented he engaged maladaptive behaviors which required consistent staff monitoring and supervision. His maladaptive behavior included disruptive behaviors (defined as yelling and dropping to the floor, and inappropriate touch ["...place his arms around your neck and attempt to jump up and down or grab arms abruptly to express his wants and needs."]) and aggression (defined as hitting, slapping, and attempts to hit or slap). d. Individual #4's PCLP, dated 9/28/10, documented an 11 year old female diagnosed with moderate mental retardation and autism. She communicated by pointing to objects and facial expressions. Her PCLP stated she required full physical assistance to complete nail care, regularly change bed linen, and complete meal planning and preparation. She required verbal prompts to wipe thoroughly after voiding, wash herself during bathing, wash her face, brush her teeth and use mouthwash, brush her hair, coordinate her clothing, tie and untie her shoes, make her bed, vacuum, take out the garbage, empty the dishwasher and clear the table. She required gesture and modeling to wash her hands. Her BIP, dated 10/20/10, stated she engaged in uncooperative behavior (defined as elopement), disruptive behavior (defined as yelling and screaming), destruction of property (defined as breaking or kicking objects), and aggression (defined as hitting, pulling hair, kicking, slapping,	W 186		

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W 186	Continued From page 15 biting, and scratching). According to her BIP, she was to be in staff's line of sight during waking hours due to her maladaptive behaviors. e. Individual #5's PCLP, dated 9/28/10, documented a 19 year old male diagnosed with profound mental retardation and autism. He communicated by some sign, some words, gestures, facial expressions, spitting, throwing, screaming, huffing, and hitting. His PCLP stated he required full physical assistance to complete all areas of toileting, showering/bathing routines, hand washing, face washing, most areas of tooth brushing, flossing, most areas of grooming, most areas of hair care, buttoning and zipping clothing, most areas of eating and dining tasks, meal planning and preparation, medication administration, fastening his seat belt, money management and shopping, and travel and traffic safety. He required verbal prompts to turn on/off water, rinse his body, dry his body completely, brush his outside upper and lower teeth, apply deodorant, comb his hair, dress, undress, remove soiled bedding and make his bed, put food in the refrigerator, and remove dishes from table. He refused to complete housekeeping tasks. His BIP, revised 10/6/10, stated he engaged in inappropriate social behaviors (defined as spitting during the course of the day), property destruction (defined as throwing and breaking his glasses, and throwing and breaking objects), uncooperative behavior (defined as refusals, not following simple commands, and throwing objects on the floor), physical aggression (defined as	W 186		

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W 186	Continued From page 16 hitting, slapping, scratching others, and throwing objects), and self abuse (defined as biting self on top of hand/wrist area causing an abrasion or cut, drawing blood). Individual #5's BIP stated he required a one to one staff person within arms length during all waking hours due to his maladaptive behaviors. f. Individual #6's PCLP, dated 9/28/10, documented an 18 year old male diagnosed with moderate mental retardation, disruptive behavior disorder and pervasive developmental disorder. He communicated by using some sign language, some words, and writing. His PCLP stated he required physical assistance to cut meat in bite sized pieces, complete nail care, put on boots, and tie his shoe laces. He required verbal prompts to complete most eating and dining tasks, use the toilet, wash hands, rinse his body, shampoo and condition hair, brush teeth, place dirty clothes in the laundry, coordinate clothing, change his bed linens, complete meal planning and preparation, and complete most housekeeping skills. His BIP, dated 10/20/10, stated he engaged in physical aggression (defined as hitting, kicking, biting, grabbing, scratching and attempts to), inappropriate social behaviors (defined as spitting on others), and uncooperative behavior (defined as refusing requests and ignoring the person making the request). According to his BIP, over the last 6 months (4/10 - 9/10), he exhibited aggression 388 times, inappropriate social behavior 59 times, and uncooperative behavior 316 times.	W 186		

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W 186	Continued From page 17 g. Observations were conducted at the facility on 10/25/10 from 3:30 - 5:15 p.m. and on 10/26/10 from 7:00 - 8:15 a.m. During that time, Individual #3 was noted to be extremely active such that he required constant supervision and Individual #4's programming was consistently disrupted, as follows: During the observation on 10/25/10 from 3:35 - 4:56 p.m., Individual #3 was noted to walk throughout the facility, periodically touching and gesturing to his staff. However, the staff person was implementing physical therapy programs with Individual #4 in the living room. It was noted the staff consistently prompted him to join herself and Individual #4 in the living room. He did not respond to the requests and continued to roam throughout the facility. Throughout the observation, the staff instructed Individual #4 to stop and follow her as she tried to redirect and assist Individual #3. During the evening meal on 10/25/10 from 4:57 - 5:16 p.m., Individual #3 was noted to repeatedly grab at the serving dishes on the dining table. Additionally, he required verbal and light physical prompts to use his utensils as he grabbed his food with his hands, and he required consistent prompts to slow his eating pace. Because of the constant needs exhibited by Individual #3 during the meal, staff was not able to attend to Individual #4. Individual #4 was left to the supervision of Individual #5's one-to-one staff. During the observation on 10/26/10 from 7:00 - 8:03 a.m., the RSC was working as a direct care staff. The RSC was noted to consistently ask nearby staff to monitor Individual #4 so that she	W 186		

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W 186	Continued From page 18 could work with Individual #3. In sum, Individual #3's extensive needs required increased staff monitoring and supervision. The facility failed to meet that need such that Individual #4's treatment was consistently disrupted. Further, given the identified needs of Individuals #1, #2, #4, #5, and #6, it would not be possible to pair any of those individuals with Individual #3 and sufficiently meet their developmental and behavioral needs. The facility failed to ensure there was sufficient direct care staff to meet Individual #3's needs.	W 186		
W 195	483.440 ACTIVE TREATMENT SERVICES The facility must ensure that specific active treatment services requirements are met. This CONDITION is not met as evidenced by: Based on observations, record review, and staff interviews it was determined the facility failed to ensure active treatment services were provided to each individual participating in the facility's program. This resulted in a lack of involvement in activities which addressed individuals' priority needs and a lack of opportunities to practice new or existing skills. The findings include: 1. Refer to W186 as it relates to the facility's failure to ensure sufficient numbers of direct care staff were available to meet individuals' needs. 2. Refer to W196 as it relates to the facility's failure to ensure individuals were provided with a continuous active treatment program.	W 195	**W 195 483.440 ACTIVE TREATMENT SERVICES** Please refer to W186 as it relates to facility staffing. Please refer to W196 as it relates to continuous active treatment. Please refer to W214 as it relates to behavioral assessments. Please refer to W218 as it relates to sensorimotor assessments. Please refer to W227 as it relates to the development of objectives. Please refer to W237 as it relates to data collection. Please refer to W239 as it relates to the development of replacement behaviors. Please refer to W241 as it relates to the location of the PCLP. Please refer to W242 as it relates to communication. Please refer to W248 as it relates to assuring that PCLP's were available for staff. Please refer to W249 as it relates to development and implementation of the training plans.	

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W 195	Continued From page 19 3. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified indivdiuals' behavioral needs. 4. Refer to W218 as it relates to the facility's fialure to ensure sensorimotor assessments were updated and accurately identified an individual's sensory needs. 5. Refer to W227 as it relates to the facility's failure to ensure objectives were developed to addressed individuals' needs. 6. Refer to W237 as it relates to the facility's failure to ensure data collection was sufficient to determine the efficacy of individuals' behavior intervention strategies. 7. Refer to W239 as it relates to the facility's failure to ensure the replacement plans for individuals' maladaptive behavior were developed to meet their behavioral needs. 8. Refer to W241 as it relates to the facility's failure to ensure individuals' PCLPs identified the location where program strategy information could be found. 9. Refer to W242 as it relates to the facility failure to ensure individuals received training related to their communication needs. 10. Refer to W248 as it relates to the facility's failure to ensure individuals' PCLPs were available to direct care staff. 11. Refer to W249 as it relates to the facility's failure to ensure individuals' training plans were	W 195		

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W 195	Continued From page 20 developed and implemented. These systematic failures resulted in the facility's inability to provide individuals with sufficient numbers of staff, comprehensive assessments, and appropriate training programs necessary to meet their developmental, communication, and behavioral needs.	W 195		
W 196	483.440(a)(1) ACTIVE TREATMENT Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services and related services described in this subpart, that is directed toward: (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and (ii) The prevention or deceleration of regression or loss of current optimal functional status. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure each individual was provided with continuous and consistent active treatment services in accordance with their individualized needs for 3 of 3 individuals (Individuals #1 - #3) whose PCLPs and training programs were reviewed. That failure resulted in a lack of active treatment plans which were pervasive, systematic and sufficient in scope necessary to meet individuals' needs. The findings include: 1. Individual #1 - #3's active treatment programs were reviewed. The programs did not include ongoing assessment of individuals' strengths and	W 196	**W 196 483.440(a)(1) ACTIVE TREATMENT** The monthly progress notes for all of the individuals in the home have been completed and are currently up to date so that progress and regression can be monitored. All of the current training programs for the individuals have been placed in the floor books so that the staff has access to the current program plans. The floor books in the homes have been revised to include only the information relevant to the current plans. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff.	

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W 196	Continued From page 21 needs based upon program data, implementation of current PCLPs, development and implementation of training programs, implementation of individualized activities, or availability of training materials, as follows: a. When asked for progress and regression program notes for Individuals #1 - #3, the AQMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., notes had not been completed for any individuals since 6/10. Without current and accurate program notes for progress and regression, the facility would not have adequate and pertinent information on which to base assessments or complete appropriate monitoring. Additionally, it would not be possible to ensure programs would be modified based upon current function. b. On 10/26/10 at 1:00 p.m., Individuals #1 - #3's program books used by staff (floor books), were reviewed and compared to Individuals #1 - #3's program charts located in the facility's office. Individuals #1 - #3's floor books each contained their BIP, Behavior Slips, and training plans related to their previous PCLP. The floor books did not contain their current PCLP (all dated 9/28/10) and related training plans. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., current PCLPs had not been put in the floor books yet, related training plans had not been developed for Individuals #1 and #2, and training plans were developed but were not implemented for Individual #3. The Acting QMRP stated they had been focused on revising and training staff on	W 196	Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including assuring that active treatment is provided. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the geueral oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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W 196	Continued From page 22 individuals' BIPs. Without access to individuals' current PCLPs and related training plans, the facility would not be able to ensure individuals were receiving aggressive and consistent training, treatment, and services in accordance with their needs as identified in their current PCLPs. c. Individual #1 and Individual #2's floor books each contained a list of fine motor activities, a list of gross motor activities, and a list of recreation and leisure activities. It was noted the lists were identical. When asked about the lists of activities noted above, the AQMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., the lists were general and were not individualized based on their needs. When asked, the RSC, who was present during the interview, stated she was not sure whether materials related to the listed activities were available for staff and individuals. Without information based upon individuals' assessed need for gross and fine motor activities, and recreation and leisure activities based upon individualized preferences, the facility would not be able to ensure individuals' routines were organized in such a way as to ensure greater independence and choice. Additionally, without availability of, and access to needed materials, it would not be possible for staff to implement identified activities. The facility failed to ensure active treatment services were sufficiently developed and implemented, and available to direct care staff, in order to ensure Individuals #1 - #3 had current	W 196		

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W 196	Continued From page 23 PCLPs, training programs, and program notes related to their progress and regression. The facility failed to ensure individuals' assessed needs for gross and fine motor activities were accurate. The facility failed to ensure recreation and leisure activities were based upon individualized preferences and needed materials were available for staff and individuals.	W 196	**W 214 483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN** Preferred Community Homes has assured that individual #2's PCLP and behavior assessments were revised to include accurate and up to date information. The monthly progress notes for all of the individuals in the home have been completed and are currently up to date so that progress and regression can be monitored. All of the current training programs for the individuals have been placed in the floor books so that the staff has access to the current program plans. The floor books in the homes have been revised to include only the information relevant to the current plans. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff.	
{W 214}	483.440(c)(3)(iii) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must identify the client's specific developmental and behavioral management needs. This STANDARD is not met as evidenced by: Based on observation, record review, and staff interview it was determined the facility failed to ensure behavioral assessments contained accurate and comprehensive information for 1 of 3 individuals (Individual #2) whose behavioral assessments were reviewed. This resulted in a lack of information on which to base program intervention decisions. The findings include: 1. Individual #2's PCLP, dated 9/28/10, documented a 17 year old male diagnosed with profound mental retardation, autism, and seizure disorder. Individual #2's PCLP stated he engaged in physical aggression towards others (defined as hitting, pinching, scratching, slapping, and pulling hair), self abuse (defined as hitting self, biting self, and banging his head), uncooperative behavior (defined as refusals and leaving a designated area unassisted), pica (defined as eating non-food items), rumination (defined as bringing ingested food back up in his mouth), and	{W 214}		

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{W 214}	Continued From page 24 food stealing. However, Individual #2's Behavioral Assessment, dated 10/18/10, did not identify or assess his food stealing behavior. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., it was an oversight and Individual #2's Behavioral Assessment needed to be revised. Further, Individual #2's Assessment stated he required one to one staffing, arms length during waking hours, to decrease incidents of food stealing and the physical dangers that could occur if he swallowed food that was not pureed texture. However, during observations on 10/25/10 and 10/26/10 for a cumulative 2 hours 30 minutes, Individual #2 was not noted to be staffed on a one to one basis. When asked, the Acting QMRP stated Individual #2 was not staffed one to one and his diet was mechanical soft, not pureed. The Acting QMRP stated Individual #2's Assessment needed to be revised. The facility failed to ensure Individual #2's Behavioral Assessment identified and assessed his food stealing behavior. The facility also failed to ensure his Assessment contained accurate information related to his staffing needs and dietary status.	{W 214}	Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including assuring that adequate assessments are completed. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	
W 218	Repeat Deficiency. 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must	W 218	**W 218 483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN** Preferred Community Homes has brought in an experienced Occupational Therapist to assess the sensory needs of each individual in the facility.	

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W 218	Continued From page 25 include sensorimotor development. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure the sensorimotor assessments were updated as needed for 1 of 3 individuals (Individual #2) whose sensorimotor assessments were reviewed. This resulted in an individual's occupational therapy assessment not being an accurate reflection of his current needs. The findings include: 1. Individual #2's PCLP, dated 9/28/10, documented a 17 year old male diagnosed with profound mental retardation, autism, and seizure disorder. Individual #2's PCLP stated he engaged in pica (defined as eating non-food items) and rumination (defined as bringing ingested food back up in his mouth). His PCLP contained a replacement behavior for pica and rumination which stated "[Individual #2] will engage in sensory activities with light physical prompting 30 times a month..." However, #2's Behavioral Assessment, dated 10/18/10, did not identify or assess sensory integration needs and his PCLP stated sensory integration was not evaluated by the Occupational Therapist. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., Individual #2 needed to be re-assessed by the Occupational Therapist to address his sensory integration needs.	W 218	Future Occupational Assessments will also be completed by an experienced Occupational Therapist. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including the sensory motor assessments for each individual. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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W 218	Continued From page 26 The facility failed to ensure Individual #2's occupational therapy assessment was updated to address his sensory integration needs.	W 218	**W 227 483.440(c)(4) INDIVIDUAL PROGRAM PLAN**	
{W 227}	483.440(c)(4) INDIVIDUAL PROGRAM PLAN The individual program plan states the specific objectives necessary to meet the client's needs, as identified by the comprehensive assessment required by paragraph (c)(3) of this section. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' PCLPs included objectives to meet their needs for 3 of 3 individuals (Individuals #1 - #3) whose assessments, PCLP, and objectives were reviewed. This resulted in a lack of program plans designed to address the needs of individuals in areas most likely to impact their life. The findings include: 1. Individual #2's PCLP, dated 9/28/10, documented a 17 year old male diagnosed with profound mental retardation, autism, and seizure disorder. Individual #2's PCLP stated he engaged in physical aggression towards others (defined as hitting, pinching, scratching, slapping, and pulling hair), self abuse (defined as hitting self, biting self, and banging his head), uncooperative behavior (defined as refusals and leaving a designated area unassisted), pica (defined as eating non-food items), rumination (defined as bringing ingested food back up in his mouth), and food stealing.	{W 227}	The PCLP for individual #2 has been revised and an objective for food stealing. The PCLP for individual #1 has been revised to include objectives to meet his emotional needs. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including verifying that the needs of each individual are met. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent.	

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{W 227}	Continued From page 27 However, his PCLP did not contain an objective related to food stealing. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., there was no objective for food stealing; it was an oversight. The facility failed to ensure objectives related to Individual #2's food stealing behavior was developed. 2. Individual #1's PCLP, dated 9/28/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's Behavioral Assessment, dated 10/18/10, stated he engaged in physical aggression (defined as hitting, biting, pinching, scratching, kicking, shoving, and head butting), self abuse (defined as biting self, hitting self, and head banging), and elopement (defined as leaving the facility without staff). Sustaining factors included "no one addressing [Individual #1's] emotional needs." However, Individual #1's PCLP did not contain objectives related to his emotional needs. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., Individual #1 did not have objectives related to his emotional needs as identified in his Behavioral Assessment. The facility failed to ensure objectives for Individual #1's emotional needs were developed.	{W 227}	Please refer to W242 as it relates to communication needs. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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{W 227}	Continued From page 28 3. Refer to W242 as it relates to the facility's failure to ensure individuals' were provided training to address their communication needs. Repeat Deficiency.	{W 227}	~~W 237 483.440(c)(5)(iv)~~ **INDIVIDUAL PROGRAM PLAN** The behavior slips for all individuals living at the facility have been revised, the current behavior slips are individualized and prompt the direct care staff to document clearly which interventions were used in relation to exhibited maladaptive behaviors and how the individuals respond to each intervention. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including verifying that all maladaptive behavior is documented in an individualized data sheet with narrative information about when interventions were used in relation to exhibited behavior. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments.	
{W 237}	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure the type of data collected was sufficient to determine the efficacy of the intervention strategies for 3 of 3 individuals (Individuals #1 - #3) whose behavior intervention programs and behavior slips were reviewed. By not ensuring appropriate data collection, the facility could not make objective decisions regarding the individuals' success or lack of success. The findings include: 1. Individuals #1 - #3's Behavior Slips, dated 10/20/10 - 10/26/10, were reviewed. The Slips contained three sections titled Antecedent, Behavior, and Consequence. Staff were required to complete the Antecedent and Behavior section in a narrative format. However, under the section titled Consequence was a list of interventions. Staff were to circle whether the BIP was followed and document the number of times each intervention was used.	{W 237}		

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{W 237}	Continued From page 29 The Consequence data did not clearly specify when the interventions were used in relation to the exhibited maladaptive behaviors and there was no information related to Individuals #1 - #3's response to the interventions. Further, Individuals #1 - #3's Slips were identical; they were not individualized. When asked, the Administrator stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., the Behavior Slips were not individualized and did not include narrative or summary information. Without comprehensive data regarding the consequence of the behavior, it would not be possible for the facility to adequately assess whether or not the individuals' behavior intervention strategies were adequate. Further, the facility would not be able to identify whether or not the staff implemented the appropriate intervention, and whether or not the intervention was effective. The facility failed to ensure the type of data collected for individuals' maladaptive behaviors provided sufficient information to adequately assess the efficacy of the intervention strategies. Repeat Deficiency.	{W 237}	The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	
{W 239}	483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify provision for the appropriate expression of behavior and the replacement of inappropriate behavior, if applicable, with behavior that is adaptive or appropriate.	{W 239}	**W 239 483.440(c)(5)(vi) INDIVIDUAL PROGRAM PLAN** Preferred Community Homes has revised the PCLP's for all six individuals to include a replacement behavior that addresses each potential function of each behavior assumed to be maladaptive.	

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{W 239}	Continued From page 30 This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior intervention programs for 3 of 3 individuals (Individuals #1 - #3) whose behavior intervention plans were reviewed. This resulted in individuals not receiving training to replace maladaptive behaviors. The findings include: 1. Individual #1's PCLP, dated 9/28/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's Behavioral Assessment, dated 10/18/10, stated he engaged in physical aggression (defined as hitting, biting, pinching, scratching, kicking, shoving, and head butting), self abuse (defined as biting self, hitting self, and head banging), and elopement (defined as leaving the facility without staff). The function of the maladaptive behaviors included wanting to see his family and being bored. Sustaining factors included "no one addressing [Individual #1's] emotional needs" and "continued difficulty in expressing wants/needs." However, Individual #1's PCLP contained one replacement behavior for all of his maladaptive behaviors which stated "[Individual #1] will take a break in a quiet area, such as his room or outside." It was not clear as to how taking a break was functionally related to wanting to see family members or being bored.	{W 239}	In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcarc Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including verifying that the needs of each individual are met including identifying replacement behaviors for each function of behavior assumed to be maladaptive. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 239}	Continued From page 31 When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., specific replacement behaviors related to the function of wanting to see family or being bored were not developed for Individual #1. 2. Individual #2's PCLP, dated 9/28/10, documented a 17 year old male diagnosed with profound mental retardation, autism, and seizure disorder. His PCLP stated he engaged in physical aggression towards others (defined as hitting, pinching, scratching, slapping, and pulling hair), self abuse (defined as hitting self, biting self, and banging his head), uncooperative behavior (defined as refusals and leaving a designated area unassisted), pica (defined as eating non-food items), rumination (defined as bringing ingested food back up in his mouth), and food stealing. Individual #2's Behavioral Assessment, dated 10/18/10, did not identify the function of his maladaptive behaviors. Sustaining factors included wanting attention and "continued inability to appropriately communicate his wants and needs." However, Individual #2's PCLP contained a replacement behavior for aggression, self abuse, and uncooperative behavior which stated "[Individual #2] will appropriately take a break on the couch with self initiation for up to 10 minutes..." It was not clear as to how taking a break was functionally related to wanting attention and communicating his wants and needs. Further, Individual #2's PCLP contained a	{W 239}		

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	13G057	A. BUILDING _____ B. WING _____	R-C 10/27/2010

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{W 239}	Continued From page 32 replacement behavior for pica and rumination which stated "[Individual #2] will engage in sensory activities with light physical prompting 30 times a month..." However, his Behavioral Assessment did not identify or assess sensory integration needs and his PCLP stated sensory integration was not evaluated by the Occupational Therapist. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., replacement behaviors were not developed for each behavior based on their function. The Acting QMRP stated Individual #2 needed to be re-assessed by the Occupational Therapist to address sensory integration. 3. Individual #3's 9/28/10 PCLP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. Individual #3's Behavioral Assessment, revised 10/19/10, stated he engaged in physical aggression (defined as hitting, slapping, and attempts to hit and slap), and disruptive behaviors (defined as yelling, inappropriate touching, and falling to the floor). The function of the maladaptive behaviors included wanting full attention, not getting attention, not getting what he wanted when he wanted it, and the inability to appropriately communicate his wants and needs. However, Individual #3's PCLP did not include replacement behaviors for his identified maladaptive behaviors. During an interview on 10/27/10 from 8:33 - 11:15 a.m., the Acting QMRP stated specific	{W 239}		

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{W 239}	Continued From page 33 replacement behaviors related to the function of Individual #3's maladaptive behaviors had not been developed due to an oversight. The facility failed to ensure appropriate replacement behaviors were identified and incorporated into the behavior intervention programs for Individuals #1 - #3. Repeat Deficiency.	{W 239}	**W 241 483.440(c)(6)(ii) INDIVIDUAL PROGRAM PLAN** The floor books have been revised for all individuals in the home and have a consistent table of contents which includes the PCLP and all related training programs. It has been clarified to all for all of the QIDP's that it is expected that the PCLP is implemented as soon as possible after the planning meeting occurs, ideally within a week. To give the QIDP's time to develop these plans in this time period a systematic change is occuring within PCH. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including assuring that PCLP's are developed and implemented in a timely manner after a planning meeting has occurred. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job
W 241	483.440(c)(6)(ii) INDIVIDUAL PROGRAM PLAN The individual program plan must identify the location where program strategy information (which must be accessible to any person responsible for implementation) can be found. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' PCLPs identified the location where program strategy information could be found for 3 of 3 individuals (Individuals #1 - #3) whose program books were reviewed. This resulted in direct care staff not having access to PCLPs or training programs for implementation. The findings include: 1. On 10/26/10 at 1:00 p.m., Individuals #1 - #3's program books used by staff (floor books), were reviewed and compared to Individuals #1 - #3's program charts located in the facility's office. Each floor book contained their BIP, Behavior Slips, and training plans related to their previous PCLP. The floor books did not contain individuals'	W 241		

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W 241	Continued From page 34 current PCLPs or training plans related to the objectives identified in their PCLPs, all dated 9/28/10. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., current PCLPs had not been put in the floor books yet. The Acting QMRP stated training plans had not been developed for Individuals #1 and #2, and training plans were developed but were not implemented for Individual #3. The Acting QMRP stated he thought they had 30 days after the PCLP was developed to implement training plans. The facility failed to ensure individuals' PCLPs identified the location where program strategy information could be found in order for staff to implement those programs.	W 241	assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	
W 242	483.440(c)(6)(iii) INDIVIDUAL PROGRAM PLAN The individual program plan must include, for those clients who lack them, training in personal skills essential for privacy and independence (including, but not limited to, toilet training, personal hygiene, dental hygiene, self-feeding, bathing, dressing, grooming, and communication of basic needs), until it has been demonstrated that the client is developmentally incapable of acquiring them. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure individuals received training in communication skills essential for independence for 3 of 3 individuals (Individuals #1 - #3) whose PCLPs and training objectives were reviewed. This resulted in	W 242	**W 242 483.440(c)(6)(iii)** **INDIVIDUAL PROGRAM PLAN** Preferred Community Homes has revised the PCLP's for all six individuals to include a replacement behavior that addresses each potential function of each behavior assumed to be maladaptive. Also, PCH has reviewed each speech assessment and verified that appropriate training programs are written and implemented for each recommendation. In some cases the team discussed the recommendations and prioritized which recommendation should be addressed first and if the needs should be addressed as service or training objectives. In these cases, the team discussion has been outlined and included within the PCLP. In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure.	

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W 242	Continued From page 35 individuals not having training programs designed to meet their communication needs. The findings include: 1. Individual #1's PCLP, dated 9/28/10, documented a 21 year old male diagnosed with moderate mental retardation, pervasive developmental disorder, and autistic and OCD traits. Individual #1's Behavioral Assessment, dated 10/18/10, stated he engaged in physical aggression (defined as hitting, biting, pinching, scratching, kicking, shoving, and head butting), self abuse (defined as biting self, hitting self, and head banging), and elopement (defined as leaving the facility without staff). Individual #1's Behavioral Assessment stated sustaining factors included "continued difficulty in expressing wants/needs." However, Individual #1's PCLP did not contain objectives related to communicating wants and needs. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., Individual #1 did not have objectives related to his communication needs as identified in his Behavioral Assessment. 2. Individual #2's PCLP, dated 9/28/10, documented a 17 year old male diagnosed with profound mental retardation, autism, and seizure disorder. His PCLP stated he engaged in physical aggression towards others (defined as hitting,	W 242	Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including assuring that needs are developed after assessments are completed. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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W 242	Continued From page 36 pinching, scratching, slapping, and pulling hair), self abuse (defined as hitting self, biting self, and banging his head), uncooperative behavior (defined as refusals and leaving a designated area unassisted), pica (defined as eating non-food items), rumination (defined as bringing ingested food back up in his mouth), and food stealing. Individual #2's Behavioral Assessment, dated 10/18/10, stated sustaining factors "continued inability to appropriately communicate his wants and needs." However, Individual #2's PCLP did not contain objectives related to communicating wants and needs. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., Individual #2 did not have objectives related to his communication needs as identified in his Behavioral Assessment. 3. Individual #3's 9/28/10 PCLP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. Individual #3's Speech Evaluation, dated 2/2/10, recommended formal communication programs for imitating fine motor, gross motor and oral motor movements, imitating a set of actions with objects, following one step directions, and using pictures to request play objects. However, his PCLP did not contain objectives related to his communication needs. When asked, the Acting QMRP stated during an	W 242		

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W 242	Continued From page 37 interview on 10/27/10 from 8:33 - 11:15 a.m., Individual #3 did not have objectives related to his communication needs as identified in his Speech Evaluation. The facility failed to ensure training plans were in place to address individuals #1 - #3's communication needs.	W 242		
W 248	483.440(c)(7) INDIVIDUAL PROGRAM PLAN A copy of each client's individual plan must be made available to all relevant staff, including staff of other agencies who work with the client, and to the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure a copy of each individual's PCLP was available to staff who worked with the individuals for 3 of 3 individuals (Individuals #1 - #3) whose program books were reviewed. This resulted in direct care staff not having access to information related to individuals' strengths, needs, likes, and dislikes. The findings include: 1. On 10/26/10 at 1:00 p.m., Individuals #1 - #3's program books used by staff (floor books), were reviewed and compared to Individuals #1 - #3's program charts located in the facility's office. Each floor book contained their BIP, Behavior Slips, and training plans related to their previous PCLP. The floor books did not contain their current	W 248	**W 248 483.440(c)(7) INDIVIDUAL PROGRAM PLAN** The floor books have been revised for all individuals in the home and have a consistent table of contents which includes the PCLP and all related training programs. It has been clarified to all for all of the QIDP's that it is expected that the PCLP is implemented as soon as possible after the planning meeting occurs, ideally within a week. To give the QIDP's time to develop these plans in this time period a systematic change is occuring within PCH. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including assuring that PCLP's are developed and implemented in a timely manner after a planning meeting has occurred.	

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W 248	Continued From page 38 PCLP, all dated 9/28/10. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., current PCLPs had not been put in the floor books yet. The Acting QMRP stated they had been focused on revising and training staff on individuals' BIPs. The facility failed to ensure individuals' PCLPs were available to direct care staff.	W 248	~~A QIDP supervisor is being hired to~~ provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent.	
{W 249}	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals received training and services consistent with their PCLPs for 3 of 3 individuals (Individuals #1 - #3) whose PCLPs and training plans were reviewed. This resulted in individuals not receiving training and services consistent with their PCLPs. The findings include: 1. On 10/26/10 at 1:00 p.m., Individuals #1 - #3's program books used by staff (floor books), were reviewed and compared to Individuals #1 - #3's program charts located in the facility's office.	{W 249}	Person Responsible: Westcare Regional Representative Completion Date: 12/1/10 **W 249 483.440(d)(1) PROGRAM IMPLEMENTATION** The floor books have been revised for all individuals in the home and have a consistent table of contents which includes the PCLP and all related training programs. It has been clarified to all for all of the QIDP's that it is expected that the PCLP is implemented as soon as possible after the planning meeting occurs, ideally within a week. To give the QIDP's time to develop these plans in this time period a systematic change is occuring within PCH. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP.	

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{W 249}	Continued From page 39 Each floor book contained their BIP, Behavior Slips, and training plans related to their previous PCLP. The floor books did not contain current training plans related to the objectives identified in their PCLPs, all dated 9/28/10. When asked, the Acting QMRP stated during an interview on 10/27/10 from 8:33 - 11:15 a.m., related training plans had not been developed for Individuals #1 and #2, and training plans were developed but were not implemented for Individual #3. The Acting QMRP stated he thought they had 30 days after the PCLP was developed to implement training plans. The facility failed to ensure training programs based upon Individual #1 - #3's current PCLPs were developed and implemented.	{W 249}	With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents including assuring that PCLP's are developed and implemented in a timely manner after a planning meeting has occurred. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent.	
{W 266}	Repeat Deficiency. 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES The facility must ensure that specific client behavior and facility practices requirements are met. This CONDITION is not met as evidenced by: Based on observation, record review, and staff interviews it was determined the facility failed to ensure techniques used to manage inappropriate behavior were sufficiently assessed, developed and monitored. This failure resulted in individuals not receiving appropriate behavioral services and interventions. The findings include:	{W 266}	Person Responsible: Westeare Regional Representative Completion Date: 12/1/10 **W 266 483.450 CLIENT BEHAVIOR & FACILITY PRACTICES** Please refer to W214 as it relates to behavioral assessments. Please refer to W237 as it relates to data collection. Please refer to W239 as it relates to the development of replacement behaviors. Please refer to W278 as it relates to less restrictive interventions.	

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{W 266}	Continued From page 40 1. Refer to W214 as it relates to the facility's failure to ensure behavioral assessments were current, comprehensive, and accurately identified individuals' behavioral needs. 2. Refer to W237 as it relates to the facility's failure to ensure data collection was sufficient to determine the efficacy of individuals' behavior intervention strategies. 3. Refer to W239 as it relates to the facility's failure to ensure the replacement plans for individuals' maladaptive behavior were developed to meet their behavioral needs. 4. Refer to W278 as it relates to the facility's failure to ensure less restrictive interventions were systematically tried and proven to be ineffective prior to implementing restrictive interventions. 5. Refer to W313 as it relates to the facility's failure to ensure behavior modifying drugs were not used until the severity of the behavior was show to outweigh the associated risks of the drugs.	{W 266}	Please refer to W313 as it relates to ensuring behavior modifying drugs were not used until the severity of the behavior was shown to outweigh the risk of the drugs.	
{W 278}	Repeat Deficiency. 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR Procedures that govern the management of inappropriate client behavior must insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective.	{W 278}	**W 278 483.450(b)(1)(iii) MGMT OF INAPPROPRIATE CLIENT BEHAVIOR** The Director of Nursing services within PCH has developed a written plan for exactly what is to occur prior to and during psych clinic meetings. The policy clarifies that a team meeting is to occur prior to team members talking with individual's doctors so that state and federal regulations can be discussed and team recommendations can be developed prior to talking with the doctor. This way the team can consider if less restrictive interventions have been attempted and documented prior to implementation of medications with harmful side effects and to discuss if the benefits of medication can outweigh the harmful effects of the medications.	

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{W 278}	Continued From page 41 This STANDARD is not met as evidenced by: Based on record review and staff interviews, it was determined the facility failed to ensure individuals' records included evidence of least restrictive or more positive techniques being utilized prior to the use of more restrictive techniques to manage behavior for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in the potential for an individual to be subjected to restrictive interventions unnecessarily. The findings include: 1. Individual #3's 9/28/10 PCLP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. a. Individual #3's Physician's Order, dated 8/10, documented he received Risperidone (an antipsychotic drug) 3 mg each evening. His Written Informed Consent for Risperidone, dated 8/24/10, stated the drug "should further increase [Individual #3's] ability to follow instructions and increase his time on task." His Medication Reduction Plan, dated 10/20/10, stated Risperidone was used for aggression, defined as hitting, slapping, and attempts to hit or slap. Individual #3's record did not include documented evidence of less restrictive interventions being systematically tried and proven to be ineffective prior to the use of Risperidone. b. Individual #3's record contained a Resident Medication Change Form, dated 9/20/10, which stated Clonidine (an antihypertensive drug) was to be started at 0.1 mg ½ tablet twice a day for 1	{W 278}	In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff Instead they are assigned to strictly focus on the programmatic needs of their assigned residents. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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PREFERRED COMMUNITY HOMES - COURTYARD	615 SECOND AVENUE WEST WENDELL, ID 83355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{W 278}	Continued From page 42 week, then increased to 1 tablet twice a day. A second Resident Medication Change Form, dated 10/15/10, which stated Clonidine was to be increased to 0.1 mg three times daily. Individual #3's Medication Reduction Plan, dated 10/20/10, stated Clonidine was used for disruptive behavior, defined as yelling, inappropriate touching, and falling to the floor. Individual #3's record did not include documented evidence of less restrictive interventions being systematically tried and proven to be ineffective prior to the use of Clonidine. During an interview on 10/27/10 from 8:33 - 11:15 a.m., the Acting QMRP stated there was no documented evidence of less restrictive interventions. The facility failed to ensure less restrictive interventions had been systematically tried and proven to be ineffective prior to the use of restrictive behavior modifying drugs for Individual #3. Repeat Deficiency.	{W 278}		
{W 313}	483.450(e)(3) DRUG USAGE Drugs used for control of inappropriate behavior must not be used until it can be justified that the harmful effects of the behavior clearly outweigh the potentially harmful effects of the drugs. This STANDARD is not met as evidenced by: Based on record review and staff interview, it was determined the facility failed to ensure behavior modifying drugs were not used until the severity	{W 313}	**W 313 483.450(e)(3) DRUG USAGE** The Director of Nursing services within PCH has developed a written plan for exactly what is to occur prior to and during psych clinic meetings. The policy clarifies that a team meeting is to occur prior to team members talking with individual's doctors so that state and federal regulations can be discussed and team recommendations can be developed prior to talking with the doctor. This way the team can consider if less restrictive interventions have been attempted and documented prior to implementation of medications with harmful side effects and to discuss if the benefits of medication can outweigh the harmful effects of the medications.	

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{W 313}	Continued From page 43 of the behavior was shown to outweigh the associated risks of the drugs for 1 of 3 individuals (Individual #3) whose restrictive interventions were reviewed. This resulted in an individual receiving behavior modifying drugs without the necessary justification. The findings include: 1. Individual #3's 9/28/10 PCLP stated he was a 12 year old male whose diagnoses included profound mental retardation, ADHD, and autism. a. Individual #3's Physician's Order, dated 8/10, documented he received Risperidone (an antipsychotic drug) 3 mg each evening. Individual #3's Written Informed Consent for Risperidone, dated 8/24/10, stated the drug "should further increase [Individual #3's] ability to follow instructions and increase his time on task." His Medication Reduction Plan, dated 10/20/10, stated Risperidone was for Aggression, which was defined as hitting, slapping, and attempts to hit or slap. Individual #3's BIP for aggression, revised 10/13/10, stated Individual #3 would "tend to slap at the staff on their arms." However, there was no documentation indicating the frequency of the behavior, or indicating the behavior resulted in harm or injury to Individual #3 or staff. The Nursing 2011 Drug Handbook stated the side effects for Risperidone included, but were not limited to, akathisia (restless legs), somnolence (a strong desire to sleep), dystonia (a neurological movement disorder), headache, insomnia, agitation, anxiety, pain, parkinsonism (tremors), suicide attempt, dizziness, fever, hallucination, mania, impaired concentration,	{W 313}	In addition, Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff Instead they are assigned to strictly focus on the programmatic needs of their assigned residents. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent. Person Responsible: Westcare Regional Representative Completion Date: 12/1/10	

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{W 313}	Continued From page 44 abnormal thinking and dreaming, tremor, hypoesthesia (a reduced sense of touch or sensation), fatigue, depression, nervousness, tachycardia (rapid heart rate), chest pain, orthostatic hypotension (blood pressure drops when standing), peripheral edema (fluid retention in the limbs), syncope (fainting), hypertension, rhinitis (runny nose), sinusitis, pharyngitis, abnormal vision, ear disorder, constipations, nausea, vomiting, abdominal pain, increased saliva, diarrhea, urinary incontinence, increased urination, weight gain or loss, hyperglycemia, and upper respiratory infection. Individual #3's record did not contain documented evidence that his inability to follow instructions or remain on task, or his tendency to "to slap at the staff on their arms" outweighed the potentially harmful effects of Risperidone. b. Individual #3's record contained a Resident Medication Change Form, dated 9/20/10, which stated Clonidine (an antihypertensive drug) was to be started at 0.1 mg ½ tablet twice a day for 1 week, then increased to 1 tablet twice a day. A second Resident Medication Change Form, dated 10/15/10, which stated Clonidine was to be increased to 0.1 mg three times daily. Individual #3's Medication Reduction Plan, dated 10/20/10, stated Clonidine was used to decrease disruptive behavior, which was defined as yelling, inappropriate touch, and falling to the floor. The Nursing 2011 Drug Handbook stated the side effects for Clonidine included, but were not limited to, drowsiness, dizziness, sedation, weakness, fatigue, agitation, depression, bradycardia (slow heart rate), severe rebound hypertension (an	{W 313}		

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{W 313}	Continued From page 45 increase in blood pressure), orthostatic hypotension, constipation, dry mouth, nausea, vomiting, anorexia, urine retention, and pruritus (an unpleasant sensation that causes the desire or reflex to scratch). Individual #3's record did not contain documented evidence that his behavior of yelling, attention seeking touch, or falling to the floor outweighed the potentially harmful effects of Clonidine. During an interview on 10/27/10 from 8:33 - 11:15 a.m., the Acting QMRP stated there was no documentation that could show the harmful effects of Individual #3's maladaptive behaviors outweighed the potential risks of the drugs prescribed to manage those behaviors. The facility failed to ensure Individual #3's Risperidone and Clonidine were used only after the risks of the behaviors for which they were prescribed were clearly shown to outweigh the potential side effects of the drugs. Repeat Deficiency.	{W 313}		
W 455	483.470(I)(1) INFECTION CONTROL There must be an active program for the prevention, control, and investigation of infection and communicable diseases. This STANDARD is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure infection control procedures were followed to prevent and control infection and/or communicable diseases. That failure had the potential to impact all individuals (Individuals #1 - #6) residing in the	W 455	**W 455 483.470(I)(1) INFECTION CONTROL** The Director of Nursing has re-trained all of the staff on infection control practices to assure that acceptable practices are being utilized. In addition she is doing hands on observations within the home so that she can give immediate feedback for staff on exactly what is an acceptable practice. Observations will continue on a weekly basis to assure that staff adequately understands infection control practices. Person Responsible: PCH, Director of Nursing Services Completion Date: 1/1/11	

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W 455	Continued From page 46 facility, and had the potential to provide opportunities for cross-contamination to occur and negatively impact individuals' health. The findings include: 1. During an observation on 10/25/10 from 3:30 - 5:15 p.m., Individual #5 was observed assisting staff with meal preparation in the kitchen. Individual #5 was observed to place his finger up his nose. The staff working with Individual #5 instructed him to remove his finger from his nose and handed Individual #5 three high-sided divided plates to set on the counter. The staff then handed Individual #5 three plastic drinking glasses to set on the counter. Individual #5 was observed to grasp the interior dividers of the plates with his bare hand and spin the plates on the counter. The staff asked Individual #5 not to play with the plates, and stated the plates were to be used by Individual #5, Individual #3, and Individual #4 for dinner. The staff continued with the meal preparations. The staff working with Individual #5 was asked about infection control procedures during the observation. The staff stated he had been trained in hand washing. When asked about Individual #5 touching the plates after he had his finger up his nose, the staff stated the plates should be replaced and he should have had Individual #5 wash his hands after he had picked his nose. During an interview on 10/27/10 from 8:33 - 11:15 a.m., the Corporate RN stated Individual #5 should have been asked to wash his hands after picking his nose, and should not have been allowed to touch the plates with soiled hands.	W 455		

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W 455	Continued From page 47 The facility failed to ensure proper infection control procedures were followed.	W 455		

PRINTED: 11/03/2010
FORM APPROVED

Bureau of Facility Standards

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(MM164)	16.03.11.075.04 Development of Plan of Care To Participate in the Development of Plan of Care. The resident must have the opportunity to participate in his plan of care. Residents must be advised of alternative courses or care and treatment and their consequences when such alternatives are available. The resident's preference about alternatives must be elicited and considered in deciding on the plan of care. A resident may request, and must be entitled to, representation and assistance by any consenting person of his choice in the planning of his care and treatment. This Rule is not met as evidenced by: Refer to W124. Repeat Deficiency.	(MM164)	**MM 164 16.03.11.075.04 DEVELOPMENT OF PLAN OF CARE** Please refer to W124 RECEIVED DEC 0 3 2010 FACILITY STANDARDS	
(MM191)	16.03.11.075.09(c) Last Resort Physical restraints must not be used to limit resident mobility for the convenience of staff, and must comply with life safety requirements. If a resident's behavior is such that it will result in injury to himself or others and any form of physical restraint is utilized, it must be in conjunction with a treatment procedure designed to modify the behavioral problems for which the patient is restrained and, as a last resort, after failure of attempted therapy. This Rule is not met as evidenced by: Refer to W278 and W313. Repeat Deficiency.	(MM191)	**MM 191 16.03.11.075.09(c) LAST RESORT** Please refer to W278 and W313	
(MM209)	16.03.11.075.15 Right to Personal Items Right to Personal Items. Each resident admitted to the facility must be permitted to retain and use his personal clothing and possessions as space	(MM209)	**MM 209 16.03.11.075.15 RIGHT TO PERSONAL ITEMS** Please refer to W137	

Bureau of Facility Standards

Tom Mills — Assistant to the Regional — 12/1/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Bureau of Facility Standards

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{MM209}	Continued From page 1 permits, unless to do so would infringe upon rights of other residents, and unless medically contraindicated as documented by his physician in his medical record. This Rule is not met as evidenced by: Refer to W137. Repeat Deficiency.	{MM209}	**MM 212 16.03.11.075.17(a) MAXIMIZE DEVELOPMENTAL POTENTIAL** Please refer to W195, W196 and W266	
{MM212}	16.03.11.075.17(a) Maximize Developmental Potential The treatment, services, and habilitation for each resident must be designed to maximize the developmental potential of the resident and must be provided in the setting that is least restrictive of the resident's personal liberties; and This Rule is not met as evidenced by: Refer to W195, W196, and W266. Repeat Deficiency.	{MM212}		
{MM271}	16.03.11.100.04(b) Storage of Toxic Chemicals All toxic chemicals must be properly labeled and stored under lock and key. This Rule is not met as evidenced by: Based on observation and staff interviews, it was determined the facility failed to ensure all toxic chemicals were properly stored under lock and key for 6 of 6 individuals (Individuals #1 - #6) residing in the facility. This resulted in the potential for individuals having access to toxic chemicals. The findings include: 1. During an observation on 10/25/10 from 3:30 - 5:15 p.m., the following toxic chemicals were found to be unlocked:	{MM271}	**MM 271 16.03.11.100.04(b) STORAGE OF TOXIC CHEMICALS** Preferred Community Homes has repaired the cabinet that was broken. In addition, PCH has developed a system in which staff can communicate any maintenance needs to the maintenance personnel through maintenance request forms. Also, the maintenance staff person in the Wendell area is now provided supervision by an experienced maintenance supervisor. With this current plan the homes in the Wendell area will be taken care of to avoid items such as broken cabinets which possess potential harm for the individuals residing there. Person Responsible: Westcare Regional Representative Completion Date: 1/1/11	

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{MM271}	Continued From page 2 a. In the laundry room: - 2 cans of Sprayway Glass Cleaner. - 1 spray bottle of Clorox Bathroom Cleaner. - 1 bottle of Clorox Toilet Bowl Cleaner with Bleach. - 2 bottles of Windex Glass Cleaner. - 4 containers of PDI Sani-Cloth Plus. b. In the linen closet: - 11 containers of PDI Sani-Cloth Plus. The MSDS (Material Safety Data Sheet) for Sprayway Glass Cleaner stated the product was classified as a "Hazardous Chemical" and was harmful to skin, kidneys, blood, and liver. The MSDS for Clorox Bathroom Cleaner stated the product could irritate skin, eyes, nose, throat, and lungs, and was harmful if swallowed. The MSDS for Clorox Toilet Bowl Cleaner with Bleach stated the product caused severe irritation or damage to eyes and skin, the vapor or mist could cause irritation, and the product was harmful if swallowed. The MSDS for Windex Glass Cleaner stated the product was toxic. The MSDS for PDI Sani-Cloth Plus stated the product was hazardous to humans and domesticated animals. The Residential Service Coordinator (RSC), who was present during the review, stated Individual #6 was known to place items in his mouth. The RSC stated she was not aware the lock on the cabinet in the laundry room was non-functional, or that the PDI Sani-Cloths were toxic. The RSC called maintenance personnel to repair the lock,	{MM271}		

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{MM271}	Continued From page 3 and removed the toxic chemicals to a secured location. The facility failed to ensure all toxic chemicals were maintained under locked conditions. Repeat Deficiency.	{MM271}		
{MM620}	16.03.11.230.05(b) Upgrading of Competencies The upgrading of competencies to improve skills based on resident needs and corresponding staff expertise; and This Rule is not met as evidenced by: Refer to W249. Repeat Deficiency.	{MM620}	**MM 620 16.03.11.230.05(b) UPGRADING OF COMPETENCIES** Please refer to W249	
{MM725}	16.03.11.270.01(b) QMRP The QMRP is responsible for supervising the implementation of each resident's individual plan of care, integrating the various aspects of the program, recording each resident's progress and initiating periodic review of each individual plan for necessary modifications or adjustments. This function may be provided by a QMRP outside the facility, by agreement. This Rule is not met as evidenced by: Refer to W159. Repeat Deficiency.	{MM725}	**MM 725 16.03.11.270.01(b) QMRP** Please refer to W159	
{MM729}	16.03.11.270.01(d) Treatment Plan Objectives The individual treatment plan must state specific objectives to reach identified goals. The objectives must be: This Rule is not met as evidenced by:	{MM729}	**MM 729 16.03.11.270.01(d) TREATMENT PLAN OBJECTIVES** Please refer to W227 and W242	

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{MM729}	Continued From page 4 Refer to W227 and W242. Repeat Deficiency.	{MM729}		
{MM730}	16.03.11.270.01(d)(i) Diagnostic and Prognostic Data Based on complete and relevant diagnostic and prognostic data; and This Rule is not met as evidenced by: Refer to W214. Repeat Deficiency.	{MM730}	**MM 730 16.03.11.270.01(d)(i) DIAGNOSTIC AND PROGNOSTIC DATA** Please refer to W214	
{MM731}	16.03.11.270.01(d)(ii) Measurable Behavioral Terms Stated in specific measurable behavioral terms that permit the progress of the individual to be assessed; and This Rule is not met as evidenced by: Refer to W237. Repeat Deficiency.	{MM731}	**MM 731 16.03.11.270.01(d)(ii) MEASURABLE BEHAVIORAL TERMS** Please refer to W237	
MM769	16.03.11.270.03(c)(vi) Control of Communicable Diseases and Infectio Control of communicable diseases and infections through identification, assessment, reporting to medical authorities and implementation of appropriate protective and preventative measures. This Rule is not met as evidenced by: Refer to W455.	MM769	**MM 769 16.03.11.270.03(c)(vi) CONTROL OF COMMUNICABLE DISEASES AND INFECTION** Please refer to W455	
{MM855}	16.03.11.270.08(c) Training and Habilitation Record	{MM855}		

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{MM855}	Continued From page 5 There must be a functional training and habilitation record for each resident maintained by and available to all training and habilitation staff which shows evidence of training and habilitation service activities designed to meet the objectives set for every resident. This Rule is not met as evidenced by: Refer to W239 W241, and W248. Repeat Deficiency.	{MM855}	**MM 855 16.03.11.270.08(c) TRAINING AND HABILITATION RECORD** Please refer to W239, W241 and W248	
MM857	16.03.11.270.08(e) Qualified Training There must be sufficient appropriately qualified training and habilitation personnel and necessary supporting staff available to carry out the residents' training and habilitation program. This Rule is not met as evidenced by: Refer to W186.	MM857	**MM 857 16.03.11.270.08(e) QUALIFIED TRAINING** Please refer to W186	

December 2, 2010

Nicole Wisenor, Co-Supervisor, Non-Long Term Care
Idaho Department of Health and Welfare
Bureau of Facility Standards
PO Box 83720
Boise, ID 83720

Dear Ms. Wisenor:

Preferred Community Homes – Courtyard alleges compliance with the Medicaid Intermediate Care Center Facility for Persons with Mental Retardation Conditions of Participation on Active Treatment, and Client Behavior & Facility Practices.

Preferred Community Homes has accomplished the following in preparation for a revisit:

- To correct the deficiencies the Westcare Regional Representative and the Assistant to the Regional have stepped in as the QIDP's for all of the individuals at the Courtyard home to assist with all functions of the QIDP. They have physically been in Wendell assisting with the revisions throughout the process. They have been assisting with staff training to assure that all staff are being and will continually be trained on all programs, as they are implemented. On the floor training has occurred and will continue to occur until we believe staff has adequate training to implement the active treatment program as written.

- Preferred Community Homes has a plan to implement systematic changes in the Administrative structure. Within the system there is a Westcare Regional Representative in the Boise/Twin Falls area that is responsible for oversight of all of the PCH programs. The assignments are being revised in regards to the responsibilities of each QIDP. With the revisions the QIDP staff within PCH is no longer responsible for the supervision of the DCA staff. Instead they are assigned to strictly focus on the programmatic needs of their assigned residents. A QIDP supervisor is being hired to provide oversight and quality assurance to the QIDP's at PCH. Also, the Administrators of each facility will be given revised job assignments. The Administrators will no longer be responsible for the oversight of the QIDP staff; instead they will be responsible for the staff in the home and the general oversight of each facility. PCH believes that with the revisions, that the general oversight with the care provided will be consistent.

- Individual #3 is currently assigned a one to one staff as part of his program plan. Currently there are 5 staff assigned to the AM and PM shifts at the home.

Preferred Community Homes has scheduled quarterly core team meetings. At the meetings the team will discuss the needs of each individual so that the team can assure that all needs are met including the staffing needs of each individual.

- In addition to the system changes mentioned above, the monthly progress notes for all of the individuals in the home have been completed and are currently up to date so that progress and regression can be monitored. All of the current training programs for the individuals have been placed in the floor books so that the staff has access to the current program plans. The floor books in the homes have been revised to include only the information relevant to the current plans.

- Preferred Community Homes has assured that individual #2's PCLP and behavior assessments were revised to include accurate and up to date information.

- Preferred Community Homes has brought in an experienced Occupational Therapist to assess the sensory needs of each individual in the facility. Future Occupational Assessments will also be completed by an experienced Occupational Therapist.

- The PCLP for individual #2 has been revised and an objective for food stealing has been developed. The PCLP for individual #1 has been revised to include objectives to meet his emotional needs.

- Preferred Community Homes has revised the PCLP's for all six individuals to include a replacement behavior that addresses each potential function of each behavior assumed to be maladaptive.

- The floor books have been revised for all individuals in the home and have a consistent table of contents which includes the PCLP and all related training programs. It has been clarified to all for all of the QIDP's that it is expected that the PCLP is implemented as soon as possible after the planning meeting occurs, ideally within a week.

- Preferred Community Homes has revised the PCLP's for all six individuals to include a replacement behavior that addresses each potential function of each behavior assumed to be maladaptive. Also, PCH has reviewed each speech assessment and verified that appropriate training programs are written and implemented for each recommendation. In some cases the team discussed the recommendations and prioritized which recommendation should be addressed first and if the needs should be addressed as service or training objectives. In these cases, the team discussion has been outlined and included within the PCLP.

- The Director of Nursing services within PCH has developed a written plan for exactly what is to occur prior to and during psych clinic meetings. The policy clarifies that a team meeting is to occur prior to team members talking with individual's doctors so that state and federal regulations can be discussed and

team recommendations can be developed prior to talking with the doctor. This way the team can consider if less restrictive interventions have been attempted and documented prior to implementation of medications with harmful side effects and to discuss if the benefits of medication can outweigh the harmful effects of the medications.

If you have any further questions, please feel free to contact me at 208-855-9142

Tom Moss
PCH-Assistant to the Regional Administrator

COPY

IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0009
PHONE 208-334-6626
FAX 208-364-1888

November 4, 2010

Tom Moss, Administrator
Preferred Community Homes - Courtyard
7091 W Emerald
Boise, ID 83704

Provider #13G057

Dear Mr. Moss:

On **October 27, 2010**, a complaint survey was conducted at Preferred Community Homes - Courtyard. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004808

Allegation: Individuals engage in maladaptive behaviors and staff do not intervene appropriately and in a timely fashion.

Findings: An unannounced on-site complaint investigation was conducted on 10/27/10. During that time, a follow up survey was in process, from 10/25/10 - 10/27/10, during which observations, record review, and staff interviews were conducted with the following results:

The facility's Accident/Injury reports and investigations were reviewed from 10/1/10 - 10/25/10. None of the documents showed individuals engaging in maladaptive behaviors without appropriate and timely intervention.

Observations were conducted at the facility on 10/25/10 and 10/26/10 for a cumulative 6 hours and 54 minutes. During that time staff were noted to appropriately intervene with individuals' inappropriate behavior in a timely fashion.

Three individuals' records were selected for review. One individual's record included a behavior data sheet, dated 10/26/10, that documented maladaptive behavior which included leaving the

facility and going to the home of a former employee (approximately three blocks from the facility). The behavior data sheet documented staff were present with the individual, but did not contain sufficient information.

During an interview on 10/27/10 from 12:57 - 1:08 p.m., the Acting Administrator provided an Incident/Accident report that provided additional information regarding the 10/26/10 incident. The Acting Administrator stated he was present at the facility during the incident. The Acting Administrator stated an individual became upset and walked from the facility to a former employee's home. The individuals' one-to-one staff was present with the individual. Due to the individual's self injurious behavior, the staff carried a backpack which contained a pillow, a helmet, and a cell phone. The Acting Administrator stated the individual walked to the former employee's home a total of 4 times, each time with the one-to-one staff present. On one occasion, the Acting Administrator and the Corporate Registered Nurse gave the individual and the one-to-one staff a ride back to the facility. The Acting Administrator stated the one-to-one staff provided appropriate intervention during the entire behavioral episode.

Four additional staff, including the one-to-one staff and the Administrator in training, were interviewed on 10/27/10 from 1:09 - 1:52 p.m. All staff provided the same information regarding the behavioral incident on 10/26/10. In sum, the following occurred:

An individual, who required one-to-one staff due to self injurious behaviors, became upset. The individual left the facility for a walk and went to the home of a former employee. The one-to-one staff carried a backpack which contained a pillow, a helmet, and a cell phone. The staff was able to redirect the individual on two of the four occasions and have him return to the facility. On the third occasion, the individual removed his shoes and sat in the yard of the former employee. The one-to-one staff was able to assist the individual to put his shoes on and redirect him toward the facility. At that time, the Acting Administrator and the Corporate Registered Nurse were able to convince the individual to get into their vehicle. They drove the individual and the one-to-one staff back to the facility.

Once back at the facility, the individual began walking towards the former employee's home. Halfway there, the individual stopped in the middle of the road and removed his shoes. The individual began to strike at the staff (knocking her cell phone to the ground) and hit his head at which point the one-to-one staff opened the backpack to remove the pillow and helmet. The individual grabbed the backpack and threw it, with the pillow, helmet, and cell phone, across the road. The individual then began to run towards the home of the former employee. The one-to-one staff followed. Once there, the individual sat on the ground. The one-to-one staff knocked on the door and requested to use the phone to call for assistance.

The AQMRP, RSC, and Administrator in training arrived at the location, having collected the

thrown items on the way, and were able to convince the individual to return to the facility.

Based on the circumstances, the one-to-one staff acted appropriately and in accordance to the individual's behavior plan.

Therefore, the allegation was unsubstantiated and no deficient practice was identified. However, the facility was cited at W237 for a lack of comprehensive data collection.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

MICHAEL CASE
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

MC/srm